G. Premiums and Cost-Sharing

1. General Provisions

Part 422, subpart G is based on the provisions found in section 1854 of the Act. These provisions were discussed in detail in the June 26, 1998 interim final rule (63 FR 35007). This subpart addresses how limits on M+C plan enrollee premiums and other cost-sharing are established through the Adjusted Community Rate (ACR) approval process. The ACR process is applicable to all M+C plans except M+C MSA plans. M+C organizations offering an M+C MSA plan are not required to submit an ACR for that plan, but they are required to submit other information for our review using the ACR process.

Section 422.300(b) provides that for contract periods beginning before January 1, 2002, M+C organizations may modify an M+C plan by adding benefits at no additional cost to the M+C plan enrollee; lowering the premiums approved through the ACR process; or lowering other cost-sharing amounts. Also prior to January 1, 2002, under §422.504(d), contracts may be for a longer period than 12 months, and may begin on a date other than January 1. In the case of such contracts, under §422.300(b)(2), ACRs must be submitted on the date specified by us. The transition rules for this period are found in §422.300(b).

Comment: One commenter suggested a revision of the ACR form used to establish the pricing structure for an M+C plan. The

commenter suggested that the new form produce more accurate information. The commenter urged that we monitor data submitted in the ACR form to determine whether established policies should be revisited.

Response: We agree. We are developing various systems to capture ACR data for policy analysis. We intend to use the data to determine the effect of established policies so that we can examine policies that need revision.

Comment: One commenter suggested that we consider alternatives to the ACR for private fee-for-service and MSA plans.

Response: Under the June 1998 interim final rule, we do not review or approve premium amounts submitted for private fee-for-service plans or MSA plans. In addition, in the case of an MSA plan, an M+C organization does not complete those parts of the ACR form that request cost information. Thus, in essence, there is an "alternative" arrangement in place for these types of plans.

Comment: One commenter suggested that we, in consultation with industry representatives, develop acceptable standards for cost accounting to be used by M+C organizations to complete its ACR form.

Response: We agree that M+C organizations should be using uniform cost accounting standards to complete the ACR form.

Therefore, we specified in §422.310(a)(5) that generally accepted accounting principles (GAAP) should be used instead of other accounting principles (for example, statutory). We have not ruled out the establishment of a standardized accounting system at this time. However, we feel that the existing accounting systems based on GAAP developed by M+C organizations should produce sufficiently accurate information for ACR purposes. We will monitor the accuracy of the ACR data produced by the M+C organizations' accounting systems through audit and other monitoring procedures.

Comment: One commenter suggested that we should either allow M+C organizations to modify their M+C plan after the M+C plan has been approved, or make the transition period rules described in §422.300(b) permanent. The commenter felt this would benefit the Medicare beneficiary.

Response: After 2002, Medicare beneficiaries will be "locked in" to their M+C plan choice for the last 9 months of the year (6 months in the case of 2002 only). The beneficiary will be locked in for the entire year if he or she wants to remain in the M+C program, and no other M+C plan in the area is open during January, February, and March. The choice of an M+C plan during the annual November open enrollment period thus will be extremely significant, since, in most cases, it will determine enrollment for the entire following calendar year. We believe that under

this program design, it is important that beneficiaries have complete information in November about what the benefits will be in each M+C plan in their area for the full following calendar year. If M+C organizations were permitted to change plan benefits mid-year, this could result in a beneficiary deciding that an M+C plan that is changing benefits would have been a better choice had he or she known in November that this change would be made, but it would be too late for the beneficiary to enroll in that plan after April 1.

We accordingly believe that beginning in 2002, (when beneficiaries will be locked in for the last 6 months of the year), benefits for a given calendar year should be established in advance of the November open season. This will allow beneficiaries to make informed decisions about which M+C plan they will choose for the following calendar year. In order for this to happen, the benefits that will apply throughout the following calendar year must be included in the ACR submission filed with us, so that these benefits can be approved by us in time to provide reliable information to beneficiaries.

Our decision to require uniform benefits throughout the calendar year after a transition period is further supported by the nature of the ACR process under M+C. As under the section 1876 risk program, the ACR process under the M+C program serves three important purposes. First, we are required to examine an

M+C organization's ACR proposal for each M+C plan to determine if Medicare beneficiaries are entitled to receive additional benefits as a result of Medicare payments that are higher than the organization's charge (adjusted for differences in utilization characteristics of the Medicare population) to a non-Medicare enrollee for a Medicare-covered benefit. Second, we are required to review ACR proposals to determine whether the pricing structure (premiums and cost-sharing charged to beneficiaries) is within the limits established by law as required under section 1854(b)(1) of the Act, and is applied uniformly to all Medicare enrollees as required under section 1854(c) of the Act. Third, we review benefit package information to determine if the benefit package is in compliance with the requirements contained in subpart C. Once this process is complete, M+C organizations are allowed to market the M+C plan as approved.

Under the M+C program, we focus on an entire calendar year in performing the above tasks. Our approval of the pricing structure of an M+C plan is based on the appropriate actuarial value of furnishing the items and services for the entire calendar year. Limits on the amount of premiums (section 1854(b) of the Act), and on the liability of the Medicare beneficiary (section 1854(e) of the Act), are based on a 12 month period. In addition, the capitation payments that will be made to the M+C organization under section 1853(a) of the Act for the M+C plan is

an integral part of establishing the value of additional benefits that must be offered under section 1854(f) of the Act. Capitation payments are based on the annual M+C capitation rate for the county (that is, the amount for the full calendar year), adjusted for various demographic and other risk factors. Section 1853(c)(1) of the Act clearly states that capitation rates are based on a contract year consisting of a calendar year. We believe that this entire scheme assumes that benefits will be the same over the 12 month period at issue. This is another reason why we believe our decision to eliminate mid-year changes after a transition period is appropriate.

2. Rules Governing Premiums and Cost-Sharing (§422.304)

This section implements provisions of the BBA relating to premiums paid by or on behalf of beneficiaries. The beneficiary in an M+C plan, other than an M+C MSA plan offered by an M+C organization, pays the monthly basic premium plus the monthly supplemental premium, if any. In the case of an M+C MSA plan, the beneficiary must pay the monthly supplemental premium, if any. The M+C monthly basic beneficiary premium, the M+C monthly supplemental premium, and the monthly MSA premium may not vary among individuals in the M+C plan, unless the M+C organization offering the plan has elected to apply this rule to individual segments of a plan service area, as provided in section 515 of the BBRA (See section I.C of this preamble). Also, the M+C

organization cannot vary the level of cost-sharing (copayments, coinsurance, or deductibles) charged for the basic benefits or supplemental benefits, if any, among the individuals enrolled in the M+C plan, again unless the M+C organization has elected to apply this rule to segments of the plan service area, as provided in section 515 of the BBRA.

As discussed in section I.C above, under section 515, the premium and cost-sharing uniformity requirements may be applied only within segments of an M+C plan's service area, with premiums or cost-sharing varying between such segments, provided: (1) a separate, and complete ACR is filed for each such segment; and (2) each segment is composed of one or more M+C payment areas. We have revised §422.304(b) to add a new paragraph (b)(2) that provides for this option.

Comment: A commenter noted that some M+C organizations offer enrollees economic incentives to use mail-order pharmacies by imposing a copayment on all prescriptions dispensed in the community pharmacies, but do not charge a copayment if the same prescription is mailed to the enrollee. The commenter wanted to know whether this practice is prohibited under the uniform cost-sharing rule in §422.304(b).

Response: The practice the commenter has described is not prohibited, since all enrollees under the plan would pay the same cost-sharing for drugs not ordered by mail, and the same cost-

sharing for drugs ordered by mail. However, an M+C organization would not be permitted to impose a structure of cost-sharing that would have the effect of denying access, as described in section 1852(d) of the Act, to an item or service advertised by the organization as being available to the enrollee.

3. Submission Requirements for Proposed Premiums and Related Information (§422.306)

This section reflects the original BBA version of section 1854(a)(1) of the Act, which prior to the BBRA provided that each M+C organization, and any organization intending to contract as an M+C organization in the subsequent year, submit specified data for every plan it intends to offer no later than May 1 of each year.

Comment: Many commenters recommended that the May 1 deadline for the submission of the ACR proposal be changed.

Response: As discussed in section I.C above, section 516 of the BBRA extended the ACR deadline permanently to July 1, and applied that extension retroactively to 1999. Therefore, we have changed our regulations at §422.306(a)(1) to reflect this statutory change.

4. Limits on Premiums and Cost-Sharing Amounts (§422.308)

Section 422.308(a) imposes a limit on the amount that an M+C organization can charge as a basic beneficiary premium for a coordinated care plan, or impose as cost-sharing under such a

plan. Specifically, the basic premium (multiplied by 12), the actuarial value of any cost-sharing, or a combination of these two forms of beneficiary liability, may not exceed the annual actuarial value of the deductibles and coinsurance that would be applicable on average to beneficiaries entitled to Medicare Part A and enrolled in Part B if they were not enrollees of an M+C organization. For those M+C enrollees who are enrolled in Medicare Part B only, the monthly basic premium (multiplied by 12), plus the actuarial value of cost-sharing, may not exceed the annual actuarial value of the deductibles and coinsurance that would be applicable to beneficiaries enrolled in Medicare Part B if they were not enrollees of an M+C organization. With respect to supplemental benefits under coordinated care plans, the monthly supplemental beneficiary premium (multiplied by 12) charged, plus the actuarial value of its cost-sharing, cannot exceed the ACR for such services.

In the case of a private fee-for-service plan, there is no limit on premium charges. However, under §422.308(b), the actuarial value of any cost-sharing imposed under the plan may not exceed the actuarial value that would apply to beneficiaries entitled to Medicare Part A and enrolled in Part B if they were not enrolled in an M+C plan as determined in the ACR. In the case of supplemental benefits, the actuarial value of cost-sharing may not exceed the ACR amounts for the benefits.

Additionally, if inadequate data is available to determine actuarial value, we can make the determination with respect to all M+C eligible individuals in the same geographic area or State or in the United States on the basis of other appropriate data.

Comment: One commenter suggested that the limits on premiums in §422.308 should not apply in the case of dual eligibles, to the extent that the Medicaid program is paying the premiums.

Response: We do not agree. Section 422.308 limits the amount that can be charged to Medicare enrollees, or anyone on their behalf, for the M+C plan. However, we recognize that the Medicaid program may pay additional amounts for Medicaid-covered benefits not included in the M+C plan. Therefore, we have clarified our jurisdiction over Medicaid benefits for dual eligibles in §422.106. (See the discussion in section II.C of this preamble.)

Comment: One commenter requested clarification of the limit on charges to a Part B-only member for Part A services.

Response: If an M+C organization chooses to include in the B-only M+C plan an equivalent Part A benefit, it may do so as an additional, mandatory supplemental, or as an optional supplemental benefit. There is a limit on what is allowed to be charged for this benefit: the lesser of the ACR for the benefit, our payment amount, (or, in the case of a working individual (or

spouse) for whom Medicare is secondary, the amount Medicare would pay if Medicare was not secondary), increased by the actuarial value of Medicare's Part A deductible and coinsurance, or the amount we charge for coverage of Part A services to those individuals that are not otherwise eligible for those services.

Comment: One commenter requested clarification of §422.308, Limits on premiums and cost-sharing amounts, that the commenter believes to be a new provision. Another commenter asked about a limit on amounts actually collected in cost-sharing.

Response: The limit on premium and cost-sharing charges in section 1854(e) is not new, and in the case of coordinated care plans, is the same as the limit that applied in the case of section 1876 risk contracts. As discussed above, in the case of a coordinated care plan, section 1854 of the Act specifically limits the amount, regardless of source, a Medicare beneficiary may be charged for the M+C plan elected. This would include premiums and cost-sharing collected by the M+C organization or any provider (either contracting or non-contracting with the M+C organization) furnishing services covered by the plan. This limit is applied to the actuarial value of the cost-sharing provided for under the M+C plan. Specifically, in the case of a coordinated care plan, the premium and the actuarial value of cost-sharing cannot exceed the actuarial value of original Medicare cost-sharing. Thus, as noted above, in approving the

ACR, we will not approve of beneficiary cost-sharing for Medicare covered services if the actuarial value of the cost-sharing exceeds the actuarial value of the deductible and coinsurance imposed under original Medicare.

Once we have approved cost-sharing amounts specified in an ACR, however, an M+C organization is permitted to collect those amounts, even if the actual amount collected turns out to exceed the amount projected in the original estimate of the cost-sharing's actuarial value. While some of our guidance has indicated that a "cap" would be imposed on the aggregate cost-sharing amount actually collected, we have determined, in examining the language in section 1854(e)(1) of the Act in response to this comment, that the limit on cost-sharing was intended to limit the amount of cost-sharing that can be provided for under an M+C plan, not on the amount that is actually collected. The statute provides that the "actuarial value" of M+C plan cost-sharing (and any premium charged) cannot exceed the "actuarial value" of cost-sharing under original Medicare. Since we do not keep track of cost-sharing actually collected under original Medicare, but instead rely only on the "actuarial value" projected up front, we believe that the same approach should apply to the M+C plan side of the equation.

We note that, as discussed above, in the case of private fee-for-service plans, the limit on beneficiary liability applies

only to cost-sharing. The actuarial value of cost-sharing for Medicare services may not exceed the actuarial value of the deductible and coinsurance imposed under original Medicare.

Comment: One commenter suggested that we set a limit on the amount that may be charged to low-income beneficiaries and beneficiaries with disabilities.

Response: Section 1854(c) of the Act requires that premium charges be uniform for all enrollees in an M+C plan (or in a segment of a plan service area as provided for in section 515 of the BBRA). As a result, a separate limit for low income beneficiaries would not be permissible. The statute also specifies the overall limits on beneficiary liability, and we do not have the discretion to change them. We note, however, that M+C organizations may not design or market M+C plans in a manner that discriminates against low-income or disabled beneficiaries.

Comment: One commenter suggested that we should prohibit the imposition of a deductible for Federally qualified health center (FQHC) services.

Response: The actuarial value of the cost-sharing imposed by an M+C organization for Medicare-covered items and services cannot exceed the actuarial value of Medicare's deductible and coinsurance under original Medicare. We establish this amount using data on all Medicare beneficiaries that did not elect a managed care organization, regardless of where the beneficiary

received the item or service. Therefore, data on items and services that do not have a deductible or coinsurance were taken into account, and M+C enrollees already have received the benefit of the fact that there is no deductible for FQHC services.

5. Incorrect Collections of Premiums and Cost-Sharing Amounts (§422.309)

Section 422.309 requires an M+C organization to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and to pay any other amounts due the enrollees or others on their behalf. We further stated that amounts incorrectly collected include: (1) exceeding the limits imposed by §422.308 (that is, exceeding the amounts approved in the ACR as falling within these limits); (2) in the case of an M+C private fee-for-service plan, exceeding the M+C monthly basic premium or monthly supplemental premium; (3) in the case of an M+C MSA plan, exceeding the M+C monthly supplemental premium, or the deductible for basic benefits; and (4) amounts collected from an enrollee who was believed ineligible for Medicare benefits but was later found to be entitled. In addition, "other amounts due" include amounts due for services that were considered an emergency, urgently needed, or other services obtained outside the M+C plan; or initially denied, but upon appeal, found to be services that the enrollee was entitled to have furnished by the M+C organization.

Comment: A commenter believes that an M+C organization should be permitted to collect additional amounts if, as a result of utilization patterns, it collects less than the amount actuarially projected in its ACR. The commenter notes that if an M+C organization collects more than the amounts permitted in the M+C plan approved in the ACR process, it has to refund amounts to enrollees, and believed that this same principle should permit the organization to collect additional amounts if it collects less than the amount projected.

Response: We do not agree. There is no indication in section 1854 of the Act that the Congress intended to allow an M+C organization to collect additional amounts from Medicare enrollees when the amount it collects ends up being less than the amount projected in its ACR. An M+C organization, when it submits its ACR, should be providing its best estimate of its charges and collections within the confines of the statute. If we accept this estimate, the M+C organization should be held to the amounts estimated. As noted above, we agree that HCFA also should be held to an estimate we have approved in the ACR process, and will not attempt to limit the aggregate amount an M+C organization can actually collect as long as it collects only approved cost-sharing amounts from any given enrollee. We believe there is a distinction between the process of projecting enrollee liability for the purpose of establishing a premium and

cost-sharing structure and the question of whether charges are made in excess of this established structure. Once the premium and cost-sharing structure is established, a charge in excess of the amounts provided for under this structure is impermissible, and grounds for sanction. A refund is appropriate. If the organization inadvertently charged less than the cost-sharing amounts approved in the ACR, it could collect the balance of the approved charge from the beneficiary. To the extent the commenter was referring to our earlier guidance discussing a limit on the aggregate amount that an organization can collect in premiums, as noted above, we have decided not to impose such a limit. This premise of the commenter's point accordingly is no longer valid.

6. ACR Approval Process (§422.310)

The June 1998 interim final rule requires that, except M+C MSA plans, each M+C organization must compute a separate ACR for each coordinated care or private fee-for-service plan offered to Medicare beneficiaries. If an M+C organization opts to apply uniformity requirements to segments of an M+C plan service area, a separate ACR must also be submitted for each such segment. We also stated in the June 1998 interim final rule that, in computing the ACR for years beginning in 2000, the M+C organization calculates an initial rate according to the specifications in §422.310(b), that represents the "commercial

premium" that the M+C organization would charge its general non-Medicare enrollees for Medicare-covered benefits and any supplemental benefits covered by the M+C plan. The M+C organization would also calculate a separate ACR value for each optional supplemental benefit it offers under the plan. Then, the organization either adjusts the initial rate by the factors specified in §422.310(c), or requests that we adjust the rate.

Section 422.310(b) dictates that the initial rate for each M+C plan is calculated on a 12-month basis for non-Medicare enrollees, using either a community rating system or a system approved by us, under which the M+C organization develops an aggregate premium for each M+C plan for all non-Medicare enrollees of that M+C plan that is weighted by the size of the various enrolled groups and individuals that compose the M+C's enrollment in that plan. Regardless of the method the M+C organization uses to calculate its initial rate, the rate must equal the premium that the M+C organization would charge its non-Medicare enrollees on a yearly basis for services included in the M+C plan.

The June 1998 interim final rule also established special rules in §422.310(d) for M+C organizations that do not have non-Medicare enrollees or sufficient Medicare enrollment experience to sufficiently calculate ACR values. We have amended §422.310(d) because the interim final rule used incorrect

citations in describing how such an M+C organization may estimate ACR values.

Comment: One commenter suggested that we test the new ACR methodology before implementation.

Response: We do not agree. The new ACR process requests data from organizations that should be readily available in an organization that has an adequate accounting system used to track the costs and revenues of the products it sells. In addition, we intend to develop a mechanism designed to identify unexpected problems. The form implementing the new ACR methodology allows M+C organizations to identify specific problems. We intend to gather information from our review, approval, and audit processes to develop manual instructions, clarify the ACR instructions, and modify the ACR form, if necessary.

Comment: One commenter suggested that the component of the ACR formula attributable to revenues in excess of expenses ("the additional revenue component," or "profit" in the case of a for-profit company) should be the same percentage of the Medicare ACR amount as it is in the case of the initial rate (the "commercial premium").

Response: We do not agree. Each product an organization offers may have a different additional revenue or profit margin. This would include each of the non-Medicare products included in the base cost figures and the initial rate. To use the same

percentage of additional revenue margin included in the initial rate for the ACR for Medicare enrollees would apply an "average" additional revenue margin for non-Medicare enrollees to all Medicare enrollees. In addition, using a percentage method, as suggested, would increase the amount of the additional revenue margin for Medicare enrollees if Medicare health care costs were higher. (If costs are higher, the profit margin percentage can be lower while producing the same amount in profit.) We believe actual additional revenues received in a prior period are the best measure of the amount of additional revenue an organization would expect in a future period, absent some changed circumstances or variables.

While we do not agree with the commenter's specific proposal, in light of this comment, we have reconsidered the relative cost ratio formula contained in the regulations at §422.310(c)(3). Since additional revenues are produced when revenues exceed expenses, we believe the best way to project additional revenues for a benefit or group of benefits is to first project total revenues of that benefit or group of benefits and, then, subtract projected total expenses of that benefit or group of benefits. Therefore, we have modified the formula in §422.310(c)(3) to project total revenues using a relative cost ratio of revenues charged in a base period for Medicare enrollees compared to revenues charges to non-Medicare enrollees of the

same period and, then, subtracting projected expenses. We have used the calendar year prior to the calendar year the ACR is submitted as the "base year" for this purpose. If an M+C organization believes the computation produced under this formula does not adequately reflect the future period for an M+C plan, the organization may, with adequate justifying documentation, make an expected variation adjustment to the amount calculated.

Comment: One commenter interpreted §422.310(c)(4) to provide that adjustments to additional revenues, after application of the relative ratios, are allowed to reduce the ACR value, but not increase the ACR value.

Response: The language of §422.310(c)(4) was incorrect as published in our June 1998 interim final rule. On October 1, 1998, we published a technical revision to this section (63 FR 52614) to clarify that adjustments may increase or decrease the amount of additional revenue included in the ACR value of the service or services. These adjustments would be allowed as long as the organization submitted sufficient documentation to justify the need to increase or decrease the ACR values so calculated.

Comment: One commenter suggested that we allow M+C organizations to use representative data to develop ACR values for an M+C plan.

Response: The new ACR process requires M+C organizations to report the costs it incurs for an M+C plan using GAAP. Organizations in business routinely review the costs of each product it sells for various reasons, (for example, budget analysis, profitability). The new ACR method does not create a new process to determine those costs. We have designed the ACR process to require the least amount of information needed to price an M+C plan without creating a new accounting process. We are relying on GAAP since these principles are widely known and are in use by most M+C organizations. We feel M+C organizations should not encounter significant problems in capturing the costs of the Medicare and non-Medicare populations of a prior period using accounting systems already in use to track each of the products it sells. Using representative data would not be as accurate as using costs actually incurred.

Comment: One commenter suggested that some group and staff model M+C organizations may not be able to provide cost data in the form and detail required in the ACR form.

Response: We do not agree. The regulations and the ACR form used to implement those regulations allow for a significant amount of flexibility. The instructions are very clear that there are a limited number of line items that must be reported. Most of the remaining entries will be dependent on the accounting system of the organization. Staff and group models may need to

use an apportionment strategy to segregate costs between Medicare and non-Medicare enrollees. These apportionment strategies should be based on the same statistics currently being submitted for the ACR form under section 1876 of the Act.

Some organizations have argued that their accounting systems cannot segregate the revenues and cost of providing services to Medicare enrollees between different service areas and among various products sold. These organizations should discuss these matters with their HCFA-assigned plan manager. Since the M+C ACR process is still relatively new, we expect to grant some flexibility to M+C organizations. M+C organizations unable to comply with ACR requirements would be required to submit a plan of action designed to bring the organization in compliance with the regulations.

7. Requirement for Additional Benefits (§422.312)

Section 422.312(b) requires that the M+C organization provide additional benefits if there is an adjusted excess amount for the plan it offers. The actuarial value of these additional benefits, less the actuarial value of any cost-sharing associated with the benefit, must at least equal the adjusted excess amounts. We received no comments on this provision, but are making a technical change to §422.312(b) to use the term "cost-sharing" rather than copayment or coinsurance because the term

cost-sharing has been previously defined in §422.2 to include copayments and coinsurance.